

TITLE COMPANIES

COMPANY NAME: _____ NAIC Company Code: _____
 Contact: _____ Telephone: _____
 REQUIRED FILINGS IN THE STATE OF: MONTANA Filings Made During the Year 2010

(1) Check- List	(2) Line #	(3) REQUIRED FILING FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE **	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 1/2" x 14")	1	EO	xxx	3/1	NAIC	
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	
	2	Quarterly Financial Statement (8 1/2" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
		II. NAIC SUPPLEMENTS						
	11	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
	12	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
	13	Schedule SIS	1	N/A	N/A	3/1	NAIC	
	14	Statement of Actuarial Opinion	1	EO	xxx	3/1	Company	T
	15	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	
	16	Supplemental Schedule of Business Written By Agency	1	EO	1	4/1	NAIC	
		III. ELECTRONIC FILING REQUIREMENTS						
	50	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	51	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	52	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	53	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	54	Quarterly Statement Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	55	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	56	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	71	Accountants Letter of Qualifications	1	N/A	N/A	6/1	Company	S
	72	Audited Financial Statements	1	EO	xxx	6/1	Company	S
	73	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	S
	74	Independent CPA	1	N/A	N/A		Company	S
	75	Notification of Adverse Financial Condition	1	N/A	N/A		Company	S
	76	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	S
	77	Request for Exemption to File	1	N/A	N/A		Company	S
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	P
	103	Copy of Annual Statement Schedule T w/Tax Report	1	0	1	3/1	Company	
	104	Filings Checklist (with Column 1 completed)	1	0	1	3/1	State	
	105	Holding Company Statement	1	0	0	4/30	State	
	106	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	Q
	107	Montana Premium Tax Report & Remittance (SAI 28)	1	0	1	3/1	State	
	108	Quarterly Premium Tax Forms (SAI 23)	1	0	1	4/15, 6/15, 9/15, 12/15	State	R
	109	State Filing Fees	1	0	1	3/1	State	
	110	Signed Jurat	0	xxx	1	3/1	NAIC	L

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing). **If Form Source is NAIC, the form should be obtained from the appropriate vendor.

	NOTES AND INSTRUCTIONS (A-N APPLY TO ALL FILINGS)
A	Required Filings Contact Person: Montana Insurance Department, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at cdonovan@mt.gov ; Michelle Scaccia at mscaccia@mt.gov ; Tim Morris at tmorris@mt.gov ; Wayne Barker at wbarker@mt.gov
B	Mailing Address: Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	Mailing Address for Filing Fees: Mailing address is same as above. The fee of \$1,900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.
D	Mailing Address for Premium Tax Payments: Same as B.
E	Delivery Instructions: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day. The premium tax return (SAI 28) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on yellow paper. If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. DO NOT combine amounts for groups of companies. Note that the tax return requires all companies remit a check for \$1,900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2009, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2010 quarterly premium tax prepayments. Montana Administrative Rules pertaining to tax payments: <u>6.6.2706 Adjustments</u> (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. <u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. <u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. <u>6.6.2708 Application of Refund</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.
F	Late Filings: The commissioner may impose a fine [Sections 33-2-701(6) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]
G	Original Signatures: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	Signature/Notarization/Certification: Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	Amended Filings: See NAIC Annual Statement Instructions for guidance on amended filings.
J	Exceptions from normal filings: Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	Bar Codes (State or NAIC) Montana is not currently using Bar Codes.
L	Signed Jurat: Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.
M	NONE Filings: See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	Filings new, discontinued or modified materially since last year: None.
O	Certificate of Compliance: Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
P	Certificate of Deposit: Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders, along with a detailed description, including CUSIP# (if available), par value, and/or amortized value and/or market value for each security listed based on the information maintained by insurer's state of domicile. Due March 1.
Q	Insurance Department Financial Examination Report: A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.

R	<p>Quarterly Premium Tax Forms and Instructions (SAI 23):</p> <p>Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2010 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December.</p> <p><u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows:</p> <p>(a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or</p> <p>(b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments.</p> <p><u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.</p>
R	<p>Quarterly Premium Tax Forms and Instructions (SAI 23) (continued):</p> <p>Include with the 2010 quarterly premium tax remittances a completed voucher form SAI 23. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2010, <u>return all four voucher forms marked "zero" with the April 15 filing.</u></p> <p>The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.</p>
S	<p>Audited Financial Statements:</p> <p>FOREIGN INSURERS ONLY – Please refrain from submitting the Audited Financial Statements to this office until further notice.</p>
T	<p>Statement of Actuarial Opinion:</p> <p>Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.</p>

**General Instructions
For Companies to Use Checklist**

Please Note: This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) (Checklist)

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) (Line #)

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings)

Name of item or form to be filed.

The **Annual Statement Electronic Filing** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The **March .PDF Filing** is the .pdf file for the annual statement, detail for investment schedules and all supplements due March 1.

The **Supplemental Electronic Filing** includes all supplements due April 1, per the *Annual Statement Instructions*.

The **Supplemental .PDF Filing** is the .pdf file for all supplements due April 1.

The **Quarterly Electronic Filing** includes the quarterly statement data.

The **Quarterly .PDF Filing** is the .pdf for quarterly statement data.

The **June .PDF Filing** is the .pdf file for the Audited Financial Statements.

Column (4) (Number of Copies)

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) (Due Date)

Indicates the date on which the company must file the form.

Column (6) (Form Source)

This column contains one of three words: "NAIC," "State," or "Company." If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions (generally, on its web site). If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

Column (7) (Applicable Notes)

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.



MONTANA INSURANCE DEPARTMENT
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2009
ANNUAL PREMIUM
TAX STATEMENT
FIRE COMPANIES
CASUALTY COMPANIES

Insurer Name				NAIC Number	
Company Mailing Address		check if new <input type="checkbox"/>	City	State	Zip Code
Tax Contact Mailing Address		check if new <input type="checkbox"/>	City	State	Zip Code
State of Domicile		Tax & Fee Contact Person		Tax Contact Person Telephone Number	
Administrative Office Telephone and Fax Numbers			Toll Free Telephone Number for Policyholder Inquiries		

SCHEDULE A - PREMIUM TAX CALCULATION

1. Total Direct premium income (Ann. Stmt: P/C-pg 19, ln 35, col 1; Health-pg 29, ln 12 & 14, col 1; Title-pg 38, ln 27, col 3, 4, 5)	\$ _____	[1]
2. Finance and service charges (Ann. Stmt: P/C-page 19 footnote a)	\$ _____	[2]
3. TOTAL PREMIUMS COLLECTED (add lines 1 and 2)	\$ _____	[3]
4. Dividends refunded or credited to policyholders (Ann. Stmt.: P/C-page 19, line 35, column 3)	\$ _____	[4]
5. Federal Exemptions - Medicare Title XVIII/Multi-Peril Crop	\$ _____	[5]
6. NET PREMIUMS per 33-2-705(1), MCA (line 3 less line 4 and 5)	\$ _____	[6]
7. PREMIUM TAX per 33-2-705(2), MCA (2.75% of line 6)	\$ _____	[7]

SCHEDULE B - FIRE INSURANCE PREMIUM TAX CALCULATION

Taxes are due and payable on the fire portion of the net direct premiums on risks resident, situated or located in Montana. Dollar amount and percentages must be used so that the calculation can be traced to the annual statement. References to rating organizations are not acceptable. Amounts in column IV are to be derived by multiplying amounts in column II by percentages in column III.

I		II		III		IV	
LINE OF BUSINESS		ANNUAL STMT. PG. 19, COL. 1 DIRECT PREMIUM		% ALLOCATION OF FIRE RISK		DOLLAR AMOUNT OF FIRE PREMIUMS	
8.	Fire			100%			[8]
9.	Allied Lines						[9]
10.	Farmowners Multi Peril						[10]
11.	Homeowners Multi Peril						[11]
12.	Commercial Multi Peril						[12]
13.	Ocean Marine						[13]
14.	Inland Marine						[14]
15.	Other Private Passenger Auto Liability						[15]
16.	Other Commercial Auto Liability						[16]
17.	Private Passenger Auto Physical Damage						[17]
18.	Commercial Auto Physical Damage						[18]
19.	Aircraft						[19]
20.	Burglary & Theft						[20]
21.	Boiler & Machinery						[21]

22.	Total Net Fire Premiums (add lines 8 thru 21, column IV)	\$ _____	[22]
23.	Tax on Fire Insurance Premiums per 50-3-109(1), MCA (2.5% of line 22)	\$ _____	[23]

SCHEDULE C -- CALCULATION OF TOTAL TAXES AND FEES

24.	Premium Tax (from line 7)	\$ _____	[24]
25.	Retaliatory Amount per 33-2-709, MCA (from Schedule E, Line 3 or 4)	\$ _____	[25]
26.	TOTAL (Add lines 24 and 25)	\$ _____	[26]
27.	Montana premium tax quarterly pre-payments	\$ _____	[27]
28.	Overpayments of prior year premium taxes (as confirmed by credit letter)	\$ _____	[28]
29.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2004-2008, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	\$ _____	[29]
30.	100% of Assessments paid in 2009 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	\$ _____	[30]
31.	Empowerment Zone New Employees – tax credit (include copy of certification from Montana Department of Labor and Industry).	\$ _____	[31]
32.	Gross Deductions (add lines 29, 30 and 31)	\$ _____	[32]
33.	Allowable Deductions (enter the smaller of line 24 or line 32)	\$ _____	[33]
34.	Total payments and credits (add lines 27, 28 and 33)	\$ _____	[34]
35.	If line 26 is larger than line 34, DIFFERENCE is TAX DUE	\$ _____	[35]
36.	Fire Insurance Premium Tax (from Schedule B line 23)	\$ _____	[36]
37.	COMPANIES MUST REMIT \$1,900 IN PAYMENT OF ALL MONTANA FEES	\$ _____ \$1,900.00	[37]
38.	TOTAL REMITTANCE (add lines 35, 36 and 37)	\$ _____	[38]
39.	If line 34 is larger than line 26, DIFFERENCE is ANNUAL TAX OVERPAYMENT	\$ _____	[39]

OVERPAYMENT must be carried forward and used to offset future periodic payments.

The above statement, and attached Schedules D and E, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

- TAX RETURN CHECKLIST** Did You Remember to:
- 1. _____ Attach Annual Statement Montana State Page?
 - 2. _____ Include Total Remittance from line 38 (at least \$1,900)?
 - 3. _____ Attach documentation for tax credits on lines 29, 30 and 31?
 - 4. _____ Indicate your company's NAIC number on front of the tax form?
 - 5. _____ Attach explanations for any unusual or extraordinary items?
 - 6. _____ Fully complete Schedules D and E and attach them to this statement?

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____

SCHEDULE D -- RETALIATORY SCHEDULE

**ATTACHMENT TO 2009 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA**


	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 6)	_____	_____
2. Tax Rate	2.75% _____	_____
3. Premium Tax	_____	_____
4. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	\$1,900.00 _____	_____
5. Annual Statement Filing Fee	N/A	_____
6. Assessment for Insurance Department Operations	N/A	_____
7. Montana Fire Insurance Premium Tax (from Schedule B, Line 23)	_____	N/A
8. Fire Marshal Tax	N/A	_____
9. Other Fire Taxes (explain) _____	N/A	_____
10. Other (explain) _____	N/A	_____
11. Other (explain) _____	N/A	_____
12. Total Montana Taxes & Fees (add lines 3 thru 7, col. A)	_____	XXXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (add 3 thru 6, and 8 thru 11, col. B)	XXXXXXXXXXXX	_____

SCHEDULE E -- CALCULATION OF RETALIATORY TAX


**ATTACHMENT TO 2009 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA**

1. Enter Amount from Schedule D, Line 13, Col. B _____
2. Enter Amount from Schedule D, Line 12, Col. A _____
3. If Schedule E, Line 1 is larger than Schedule E, Line 2 enter difference on
this line and transfer this amount to Schedule C, Line 25 _____
4. If Schedule E, Line 2 is larger than Schedule E, Line 1, enter \$0 on this
line and transfer \$0 to Schedule C, Line 25 _____

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

 <p>MONTANA INSURANCE DEPARTMENT 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040</p>		<p>PREMIUM TAX REFUND REQUEST FORM</p> <p style="text-align: right;">6.6.2708, ARM</p>	
Insurer Name			NAIC Number
Mailing Address	City	State	Zip Code
State of Domicile	Contact Person and Telephone Number		FEIN Number
Reason for decrease in estimated premium tax liability for 2010. <div style="height: 200px;"></div>		Method of calculation for refund. Calculation subject to audit by Department A. 2009 Overpayment \$ _____ 2010 Pre-payment Requirement: B. 100% of 2009 Tax \$ _____ or C. 90% of 2010 Tax * \$ _____ 1. 2009 Overpayment \$ _____ (A from above) 2. Prepayment required \$ _____ (B or C from above) 3. Amount of Refund \$ _____ (1 minus 2) * Please explain in left hand column.	
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
Subscribed and sworn to before me this _____ day of _____, 20 _____. <div style="text-align: right; margin-right: 100px;"> _____ (Notary Public) Residing at _____ My commission expires _____ </div>			

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

 <p>MONTANA INSURANCE DEPARTMENT 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040</p>		<p>CESSATION OF BUSINESS NOTIFICATION FORM</p> <p>6.6.2707, ARM</p>	
Insurer Name			NAIC Number
Mailing Address		City	State
State of Domicile		Contact Person	Contact Person Telephone Number
<p>Explanation of adjustment to quarterly tax pre-payment.</p>			
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
<p>Subscribed and sworn to before me this _____ day of _____, 20____.</p> <p style="text-align: right;">_____ (Notary Public)</p> <p>Residing at _____</p> <p>My commission expires _____</p>			



State of Montana

**PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2010**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '09 premium tax liability (#7 from tax return)
or 90% of anticipated 2010 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2010 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2009 overpayment applied to this
payment (*see line #39 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2010**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '09 premium tax liability (#7 from tax return)
or 90% of anticipated 2010 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2010 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2009 overpayment applied to this
payment (*see line #39 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2010**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '09 premium tax liability (#7 from tax return)
or 90% of anticipated 2010 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2010 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2009 overpayment applied to this
payment (*see line #39 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2010**

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

1. '09 premium tax liability (#7 from tax return)
or 90% of anticipated 2010 tax \$ _____
2. Less allowable deductions (*See instructions on back*) \$ _____
3. Total 2010 quarterly pre-payment (*line #1 - #2*) \$ _____
4. Enter 25% of the amount on line #3 \$ _____
5. Amount of 2009 overpayment applied to this
payment (*see line #39 of the tax return*) \$(_____)
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ _____
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (11/09)

QUARTERLY TAX PAYMENT INSTRUCTIONS**Line #2 Instructions**

The quarterly amounts should be reduced by subtracting the following **allowable deductions**:

- A. Anticipated 2010 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2005-2009): \$ _____
- B. Montana Comprehensive Health Association assessments: \$ _____
(excluding HIPAA Plan Liability assessments)
- Total allowable deductions to transfer to line #2 (on front):** \$ _____

Other Instructions

Please do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2010.

If insurer deems the total 2010 quarterly pre-payment requirement on line #3 to be a minimal amount (less than \$100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2010.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2010 anticipated premium tax.

If you have any questions, please contact our office at (406) 444-2040.

QUARTERLY TAX PAYMENT INSTRUCTIONS**Line #2 Instructions**

The quarterly amounts should be reduced by subtracting the following **allowable deductions**:

- A. Anticipated 2010 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2005-2009): \$ _____
- B. Montana Comprehensive Health Association assessments: \$ _____
(excluding HIPAA Plan Liability assessments)
- Total allowable deductions to transfer to line #2 (on front):** \$ _____

Other Instructions

Please do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2010.

If insurer deems the total 2010 quarterly pre-payment requirement on line #3 to be a minimal amount (less than \$100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2010.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2010 anticipated premium tax.

If you have any questions, please contact our office at (406) 444-2040.

QUARTERLY TAX PAYMENT INSTRUCTIONS**Line #2 Instructions**

The quarterly amounts should be reduced by subtracting the following **allowable deductions**:

- A. Anticipated 2010 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2005-2009): \$ _____
- B. Montana Comprehensive Health Association assessments: \$ _____
(excluding HIPAA Plan Liability assessments)
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